STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013332	A. BUILDING **01** B. WING _____	**05/11/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGES AT OAK RIDGE, THE	**1694 TROY ROAD** **WASHINGTON, IN 47501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An Initial Life Safety Code Certification and State Licensure Survey for a new facility with 58 certified Comprehensive beds and 38 Residential beds was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Dates: 05/11/15 Facility Number: 013332 Provider Number: 013332 AIM Number: NA At this Initial Life Safety Code and Environmental survey and Quality Assurance Walk thru survey, the portion of The Villages At Oak Ridge which will be certified was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and with 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities. The residential areas were found in compliance with 410 IAC, 16.2-5-1.5, Sanitation and Safety Standards and 16.2-5-1.6, Physical Plant Standards of the Indiana Health Facilities Rules for Residential care facilities. This building was one story and determined to be of Type V (111) construction and was fully sprinklered. This facility had a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 rooms. The Health Care facility has a capacity of 58 and had a census of 0 at the time of this survey. All areas where the residents have customary access were sprinklered, and all areas providing facility services were sprinklered.	K 000		